Summary Report: Focused Policy Discussions on Medicaid Reform

Background
During August and September 2006, the Division of Medicaid held several "Focused Policy Discussions" with Medicaid stakeholders to gather input on various aspects of Medicaid reform. These meetings provided helpful input as Medicaid refines the rule changes reflecting reform. The meetings also provided stakeholder input on the implementation of several Medicaid reform initiatives that require additional design work or strategies for managing policy challenges.

The reform initiatives that were the subject of these meetings fell into three categories:

1) Initiatives that have near-complete designs and drafted rules. Medicaid gathered stakeholder input to refine the draft rules. Meetings of this type were held on:
    a. School-based services
    b. Supportive living / residential habilitation
    c. Mental health clinic credentialing
    d. Long-term care financing
    e. Self-direction.
2) Initiatives for which Medicaid needed some stakeholder input into both program design and rules. Meetings of this type were held on:
    a. Preventive health assistance (PHA) benefits and premiums
    b. Application process and "triggers" for benefit plan changes.
3) Initiatives that required major stakeholder input before Medicaid could move forward with program design. Meetings of this type were held on:
    a. Caregiver support benefits
    b. Co-payments
    c. Home and Community Based Services moving under State Plan authority.

Medicaid will weigh all input carefully before deciding whether to incorporate the input into rule changes or program design. A summary of the issues and stakeholder input received at these meetings follows.

School-Based Services
Medicaid staff and attending stakeholders discussed the new Intergovernmental Transfer (IGT) administrative process requirements, the alignment of school-based reimbursement rates with other community-based rates for non-school providers, the elimination of Medicaid reimbursement for development of Individualized Education Plans (IEPs), and Medicaid Basic Plan benefits for School Based Services (IDAPA 16.03.09).

Stakeholder input included:

- Medicaid should clarify that service providers contracting with school districts cannot also bill Medicaid for services provided through contracts with districts.
- The wording "charter schools" should be used more consistently throughout the rules.
- Medicaid should clarify how contracted services by outside providers need to be reimbursed in the schools.

- Attendees thought the rules are in a better format and are clearer than before they were rearranged to reflect Medicaid reform.

Supportive Living / Residential Habilitation
There were no major objections to proposed rule changes. Attending stakeholders made two technical recommendations for rule changes. One suggestion was made to accommodate reimbursement rate changes without having to the change rules. The other suggestion was made to allow for continuation of intense supports even when goals for independence are met.

Additional suggestions were made for program improvements, including having the sex offender risk assessment reimbursed by Medicaid, and giving participants the ability to maintain intense services even if the participant improves due to intense supports, rather than losing needed support and re-qualifying after decreasing in independence.

Mental Health Clinic Credentialing
Stakeholder comments on the credentialing rules included:

- Medicaid should improve the clarity and consistency of the credentialing rules and add definitions of several terms.
- Medicaid should consider extending Temporary Credentialing if an agency is unable to complete Credentialing status within the time limit.
- Medicaid should clarify whether credentials are agency- or site-specific.
- Medicaid should add text and direction in rule to improve guidance on credentialing and how providers will be evaluated.
- Medicaid should consider creating a mechanism for participants to report complaints, to receive advice on alternative providers, and to trigger investigations.

Long-Term Care Financing
Attending stakeholders did not voice any concerns with proposed rule changes. Medicaid staff and attending stakeholders walked through the rules and together noted several minor edits and technical corrections.

Self-Direction
Attending stakeholders had no major objections to the rules, but echoed two areas of concern with self-directed services heard during the public comment period: that there is no requirement for criminal history checks of service providers in the Self-Direction program and that guardians may be used as providers. Medicaid staff outlined the rationale for these program design decisions, including the need for a cultural shift from the traditional service model to a self-directed model, the need to balance participant choice and protection, the existence of quality assurance procedures under the self-directed model, and the existence of a Department-approved form for waiving a criminal history check. Attending stakeholders commented that they would be willing to remain open-minded about the quality assurance plan developed by the Department to address areas of concern.

Stakeholders also recommended adding a definition of the term "goods" to the rules.

Preventive Health Assistance (PHA) Benefits and Premiums
Attending stakeholders provided significant input into both program design and rules text. Input fell into several major categories as follows:

- Stakeholders suggested differentiating between the two types of PHA benefits in rule text and in communication strategies (note: the "wellness" PHA is designed to help pay premiums for children who are up-to-date on recommended exams and immunizations, and the "behavior" PHA supports weight management and tobacco cessation).
- Stakeholders recommended that Medicaid consider partnerships with different entities that might be able to assist with outreach on the PHA benefits or that might be able to impart "lessons learned" from development of similar programs (such as insurance companies).
- Stakeholders made many suggestions about the use of incentives to encourage participation in PHA benefits. They recommended that the Health Questionnaire clearly state that questionnaire answers establish eligibility for PHA benefits. There were also suggestions about additional healthy behaviors that should be incentivized in the future, such as staying current on dental exams, blood pressure management, substance abuse management, healthy eating, and appropriate use of hospital emergency rooms.
- There was also a suggestion to establish baseline data on behaviors and what types of PHA incentives can improve behaviors.

Application Process and "Triggers" for Benefit Plan Changes
This meeting was held in order to clarify the process by which Medicaid participants enroll in the new Medicaid Basic Plan and Medicaid Enhanced Plan as well as the process by which participants may move from the Basic Plan to the Enhanced Plan.

Peggy Cook of the Division of Welfare explained plans for improving the Application for Assistance, including the fact that a new on-line application will be used in one field office as a trial in the fall, and will be rolled out to other field offices and partner organizations. Stakeholder feedback included the following:

- The application would be easier to fax if the format was in portrait instead of landscape.
- The application would be easier to fax with a different color scheme.
- It's important to have both a Spanish and English version of the application.

Tom Kearns of the Division of Medicaid explained the use of certain information on the Application for Assistance that is used to "trigger" enrollment in the Enhanced Plan, including if the applicant is eligible for Medicaid and is also receiving Social Security Income payments, is age 65 or older, is eligible for Medicare, or is residing in a nursing home, assisted living, or intermediate care facility for the mentally retarded (ICF-MR). The Health Questionnaire was also discussed. Stakeholder input included:

- The Health Questionnaire should clearly state that it is a voluntary form.
- The flow of the questions would be better if pregnancy questions were moved to the front with other health questions.

Diane Miller of the Division of Medicaid explained the use of the new Comprehensive Assessment form for determination of mental health needs. This form helps certain mental health providers to note a diagnosis that would qualify a Medicaid participant for services in the Enhanced Plan. Attending stakeholders requested that Medicaid consider:

- Distributing the Comprehensive Assessment through the Mental Health authority in Microsoft Word format.
- Developing a mechanism for mental health providers to find out how many units of Comprehensive Assessment have been used for the year and what the results of existing Assessments are.
- Clarifying wording in rule about individuals being harmful to themselves or others and consider moving this wording to another section of rule.
- Creating a referral system interface with Social Security.
- Changing the H0002 form to read "Mental Health Evaluator" instead of "Provider."

Caregiver Support Benefits

Medicaid staff and attending stakeholders discussed ways to design the Caregiver Support benefits authorized by House Bill 877. Idaho Medicaid intended these benefits to fit within the scope of a Section 1115 Medicaid waiver. However, federal authority for Idaho Medicaid reform was procured through State Plan amendments instead of a waiver, and Medicaid is now challenged by the task of providing a respite benefit to a population that is not otherwise eligible. Stakeholders suggested several possible models and resources for the program for consideration once Medicaid resolves the financing and eligibility challenge:

- The Area Agencies on Aging have received new funding through "National Family Care Giver Support" that may serve as a resource.
- Medicaid should consider using as possible models the respite care benefit in the Aged and Disabled waiver, the respite benefit in the Developmental Disabilities program, and the Care Club model for adult daycare.
- Medicaid should consider a voucher system for respite care.
- Medicaid should consider using the fiscal intermediary model already approved by CMS as part of the Self-Direction program.
- Medicaid should consider funding assistive technology as part of a respite benefit.

Co-Payments

Medicaid staff and attending stakeholders reviewed the new Idaho Code pertaining to Medicaid co-payments (§56-257) and new federal co-payment law in the Deficit Reduction Act of 2005 (DRA), and discussed possible implementation strategies for the following co-pays suggested in Idaho Code.

Non-preferred prescription drugs:

The existing Medicaid preferred drug list process mimics what is presented in Section 6042 of the DRA but does not use a co-payment. Implementation of a co-payment for non-preferred prescription drugs would undermine the current preferred drug list process and would expose

the state to increased costs. The current Medicaid pharmacy program utilizing the enhanced prior authorization process has been successful, and it was the consensus of attending stakeholders that Medicaid should not add co-payments that could undermine that process.

Inappropriate use of hospital emergency rooms:
There was significant discussion around the provisions of section 6043 of the DRA dealing with inappropriate use of the emergency room. The Idaho Hospital Association identified several areas of concern with provisions of Section 6043 and stated that overall these requirements are a barrier to hospital participation in co-pay implementation. Other attending stakeholders noted that promoting appropriate ER utilization may require tools additional to co-pays, such as incentives for improvement in appropriate use. The general consensus was that Medicaid should partner with hospitals to educate Medicaid participants on appropriate ER use and should consider implementing co-pays in the future.

Non-emergent use of emergency transportation:
Medicaid already downgrades claims to the level of transportation provided. Implementation of a co-payment for use of emergency transportation for non-emergent reasons may not be difficult. Medicaid will move forward with developing a process, rules, etc. to implement this co-pay.

Missed appointments with health care providers:
Missed appointments are not technically Medicaid-covered services and are therefore not candidates for participant co-payments. Rather, if a provider has a consistent practice of charging fees for missed appointments to all patients, regardless of payer, the provider could impose the same charge on Medicaid participants, and this could serve as the co-pay. Providers must follow currents standards, including notifying the participant that they will be charged for missed appointments.

Home and Community Based Services (HCBS) Moving Under State Plan Authority
The Deficit Reduction Act of 2005 permits states to offer HCBS as a Medicaid state plan option rather than through a waiver. Effective January 1, 2007, the state plan option may be used to cover eligible individuals with family incomes up to 150 % of the federal poverty level (FPL). Attending stakeholders identified several concerns with moving HCBS into the Medicaid State Plan authority:

- Currently eligible individuals should not lose eligibility, so Medicaid should find a way to keep the upper limit at 300% of Social Security Income rather than change it to 150% FPL.
- Medicaid should develop needs-based criteria for the State Plan and increase the required institutional level of care.
- Medicaid should ensure that it maintains the Self-Directed care option.
- Medicaid should keep the 1915c waiver that provides authority for existing waiver services not on the State Plan.